

MEDICAL CARE PLANS FOR LOW INCOME FARM FAMILIES

Developed by the Farm Security Administration

M 46M
Office 1939
MAY 19 1939

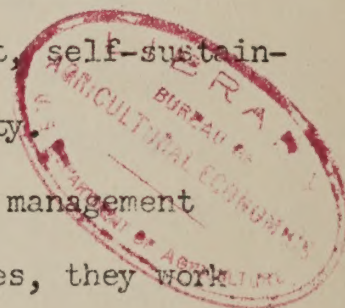
Through the co-operation of state medical associations, the Farm Security Administration has developed plans under which more than 120,000 low-income farm families in 23 states are being helped to obtain medical care at a cost which they can afford.

The Farm Security Administration found it necessary to help provide such medical care in the course of its efforts to rehabilitate more than 700,000 low-income and destitute farm families. Quite aside from any humanitarian purposes it has, as a lending agency, found that a family in good health is a better credit risk than a family in bad health. It has developed plans for medical care because it has found that good health is a necessary part of a family's economic rehabilitation.

The rehabilitation program grew out of the relief problem. More than a million farm families were on relief in 1933. Instead of carrying these families on relief indefinitely, the government seeks to get them back onto their feet, so they can become independent, self-sustaining units in the social and economic life of the community.

Advice is offered by trained agricultural and home management supervisors. Together with the farmers and the farm-wives, they work out plans for the successful operation of the farms and homes. Then loans are made to them by the government so that they can finance the program.

Rehabilitation loans usually average about \$300. They are



THE HISTORY OF THE
CITY OF BOSTON

The city of Boston, situated on a neck of land between the harbor and the bay, has been the seat of government since the first settlement of the Puritans in 1630. It was the first city in America to have a city government, and it was the first to have a city council. The city of Boston has a long and rich history, and it has played a major role in the development of the United States. It was the site of the Boston Tea Party, the Boston Massacre, and the Battle of Boston. It was also the site of the first public school, the first public library, and the first public hospital. The city of Boston has a rich cultural heritage, and it is home to many of the most important museums and universities in the United States. The city of Boston is a city of many firsts, and it is a city that has played a major role in the development of the United States.

chiefly used to buy farm equipment, livestock, work animals, fertilizer, seed and the like. The loans carry interest at five percent and are secured by crop liens and mortgages on livestock. Experience has shown that they are generally repaid.

Only farmers who cannot obtain credit elsewhere are eligible for this kind of help. In most cases they are at the end of their rope. At best, they are poor credit risks from the ordinary business standpoint, and the government's security is dependent upon their success.

Borrowers, in order to repay their loans, must be in reasonably good physical condition. They must be able to do ordinary farm work. Provision for medical and dental care is often an important and necessary part of their rehabilitation.

Before any medical care plan is set up, agreements outlining the general provisions are reached with the State Medical Association and local medical societies. Then local medical societies in areas where the need seems greatest work out with the Farm Security Administration representatives the details of a medical care plan for borrower families.

In general, the medical care plans are simple. They are based on the borrower's ability to pay for medical services, as determined by his farm plan; on free choice of physician; and on the setting aside of funds, in the hands of a trustee, at the beginning of the operating period.

The amount paid for participation varies in different localities. The usual payment is between \$15 and \$30 a year per family. When necessary, the Farm Security Administration will increase the size of its loan to enable a borrower family to participate. The details vary, but under the plan in most general use, a part of the pooled funds held by the trustee

is allocated for hospitalization and emergency needs, including surgical care, at the beginning of each period. The remaining fund is then divided into equal monthly allotments for the period covered.

Physicians submit monthly statements to the trustee for services rendered. If the total bills for a given month exceed the amount available, all bills are proportionately reduced and each physician paid his pro rata share of the month's allotment. If the allotted funds for the month are sufficient, the bills are paid in full; if a balance remains, it is carried forward to the next month or to the end of the period, and then used to complete paying bills for months in which funds were not adequate.

Under an alternative plan in limited use, funds in the hands of the trustee are kept separate for each family. The physician chosen by the family agrees to provide medical care for a certain period. If the bills for medical care are less than the sum set aside, the remainder is refunded to the family. If the cost of medical care exceeds the amount set aside by the individual family, the physician continues his attendance during that period without additional compensation. This plan ordinarily does not provide for hospitalization. Occasionally it is varied to provide for the pooling of a certain amount from all families to meet hospitalization and other emergency needs.

Experience with the two plans clearly indicates that for low-income families the first plan is preferable, that is, a plan providing for pooling the individual loans in one general fund. In case of

catastrophic illness it is impossible for any family in this income group to pay individually for hospitalization and special medical care without financial ruin or without destroying the hope of solvency for years to come: yet, it is unfair to ask a physician to handle such a case for a fee which does not anticipate such long and special attention. The pooling of funds serves as a form of voluntary insurance against disaster for the farmer and against unreasonable hardship for the doctor.

Both plans embody principles worthy of note. By establishing funds for medical care in advance, they encourage a sane acceptance of preventive medicine. In many areas, local physicians previously have served Farm Security Administration borrowers with little or no compensation. Most families, owing the doctor or unable to pay, have postponed requests for medical care as long as possible, perpetuating minor disabilities or allowing illness to become serious.

In both plans, payment for medical care is based on the expected income of the family. The physicians utilize a uniform fee schedule as the basis for their charges, but they agree to accept a pro rata reduction in payment of bills when available funds are insufficient to pay the bills in full. Many physicians were at first distrustful of this deviation from customary procedure, but learning that families embraced under this plan have total net incomes averaging from \$20 to \$300 a year, they have realized that the families would be unable to pay heavy fees, even in an emergency.

Some doubts were also expressed about the workability of plans which call for advance payment for medical care when no illness may occur to the

family during the year. Experience has cleared up doubts. Most families feel that the security of the plan is worth the investment.

Fears were voiced that participating families would abuse their privilege by requesting unnecessary medical attention. In most of the counties where the plans have been understood and adopted this expected abuse has failed to materialize. Often it happens that families will visit their physicians or summon them during the first few weeks more or less for the novelty of the thing--to see if the plan really works. When they find that the physicians do render service as agreed, they are satisfied. In those rare instances where families are unreasonable in requesting an excess amount of service, the local representative of the Farm Security Administration tries to adjust matters--generally with success. If this fails, the family may be dropped from the program.

Physicians are, in general, pleased with the program. Most of the families aided under the plan have been able to pay very little or nothing in the past, but are now able to pay at least a substantial part, if not the full amount, of their sickness bill.

County plans for medical care are in operation in 56 of Arkansas' 75 counties, in 12 counties in Missouri, 40 in Mississippi, 12 in Texas, 20 in Alabama, 85 in Georgia, 7 in Ohio, 5 in Tennessee, 2 in Indiana, 7 in Oklahoma, 3 in Iowa, 4 in New Mexico, 3 in Virginia, 6 in North Carolina, 12 in South Carolina, 1 in Montana, 2 in Idaho, 15 in Louisiana, 1 in New Jersey.

Agreements for county medical care plans have been reached with

the state medical associations of Florida, Wisconsin, Utah, Colorado, Maine, Vermont, New Hampshire, Kansas and West Virginia. Plans are under discussion with local medical societies in these states.

The financial report of a typical county group health association will demonstrate how the program works. The association, the report of which is given below, was sponsored by the Farm Security Administration but is now conducted by borrower families. It is operating in a county in a Southern state in which more than 300 farm families are Farm Security Administration borrowers; 307 families are members of the association, paying an average of approximately \$27 per year. The financial report for 1938 follows:

Financial Report for the Year 1938

Membership fees: 307 members @ average fee - \$27.15 --\$8,334.00

<u>Medical Fund</u>				<u>Hospital Fund</u>			
\$5,278.20 - 63.3%				\$2,639.10 - 31.7%			
Monthly allotment \$439.85				Monthly allotment \$289.92			
Bills Presented	Bills Paid	Per cent Payment		Bills Presented	Bills Paid	Per cent Payment	
Jan.	\$427.13	\$427.13	100%	\$ 10.00	\$ 10.00	100%	
Feb.	671.03	439.85	66%	251.00	219.92	88%	
March	516.59	439.85	86%	79.00	79.00	100%	
April	649.91	439.85	68%	296.00	219.92	74%	
May	492.40	439.85	89%	188.50	188.50	100%	
June	599.23	439.85	74%	327.50	219.92	67%	
July	825.30	439.85	53%	192.50	192.50	100%	
Aug.	612.97	439.85	72%	224.50	219.92	98%	
Sept.	521.88	439.85	84%	200.00	200.00	100%	
Oct.	617.40	439.85	71%	378.50	219.92	58%	
Nov.	493.95	439.85	89%	190.00	190.00	100%	
Dec.	827.49	439.85	53%	276.00	219.92	80%	
ANNUAL DISTRIBUTION OF SURPLUS							
Accumulated balances		12.72				433.95	
Hospital fund s'plus		25.60					
Admin. surplus		76.07					
TOTALS	\$7,255.28	\$5,379.87	74%	\$2,613.50	\$2,613.50	100%	

ADMINISTRATION

\$416.70 - - 5%

Salaries	\$172.50	Postage	\$24.00
Supplies	73.13	Bond Premium	37.50
Equipment	33.50	To Medical Fund	76.07

- - - - -

No. of family members - - - - -	307
No. of persons - - - - -	1,653
No. of families having one or more persons receiving medical care -	291
No. of persons receiving medical care - - - - -	913
Per cent of families having one or more persons receiving med. care	95
Per cent of persons receiving medical care - - - - -	55
No. of persons receiving hospitalization, or surgery, or both- - -	78
Home visits - - - - -	918
Office calls - - - - -	1,717
No. of physicians participating - - - - -	16

*Bills incurred	TOTAL - - - - -	-\$9,868.78
	Medical Service - - - - -	7,255.28
	Hospital Services - - - - -	2,613.50
	Aver. bill incurred per member family - - -	32.16
	Aver. medical bill per person receiving medical care - - - - -	7.95
	Aver. Hospital bill per person receiving hospitalization (and surgery)- - - - -	33.51

* - Bills were presented for medical and hospital care and surgery on the basis of a fee schedule which was reduced 25% or more from regular fee rates.

- - - - -

There is a somewhat different approach to the problem of medical care in homestead projects established by the Farm Security Administration. In most of these communities, from 100 to 200 families have settled on adjoining farms. When these projects are located some distance from cities, the problem of medical care for the homesteaders is often an acute one. In a few instances, they have employed a physician living nearby on a part-time basis. Occasionally, it has been necessary to attract a resident

physician to the project, by setting up a program providing a basic guaranteed income. In most cases, however, the services of all nearby physicians are utilized. Medical care programs have been organized on 30 projects, and programs are now being set up on 8 other projects.

In several communities the homesteaders have themselves organized voluntary beneficial associations which have worked out special agreements with physicians and hospitals. In some instances the families pay regular membership dues in cash, without help from the FSA. In certain other projects the Farm Security Administration loans money to the homesteaders for this purpose, and these loans are later repaid when the crops are sold. A wide variety of arrangements for medical care are in effect in these community projects.

A few facts regarding a typical project program will illustrate how the medical care needs of the homesteaders are being met. Every one of the 141 families on this project became a member of the health association, paying in advance \$18 per family for general practitioner care for one year. All five physicians living nearby participated, agreeing upon a uniform fee schedule which represented a moderate reduction in their usual fees. An average of 83.5% payment was made on medical bills throughout the first year, the monthly payments ranging from 64.5 percent to 100 percent. Of the families in the association, 96 percent had one or more of their members receiving service during the year, and 47 percent of the families received service for which the charges exceeded the \$18 membership fee. The physicians and the families alike expressed themselves

as pleased with the results of the program which is now being expanded, with an increase in dues to \$30, to include limited hospitalization and specialists' services.

Aside from placing public health nurses on about 25 of the projects, the Farm Security Administration is avoiding subsidizing medical care programs whenever possible. In most of the projects the families carry the full financial burden themselves. In four projects the program represents an interesting combination of subsidy and voluntary support from those families who wish to avail themselves of extra services not covered by the subsidy.

Special medical care plans, made necessary by local conditions, are in operation on a state-wide basis in North and South Dakota, California and Arizona.

In North and South Dakota, a special plan of medical care was needed because of the large number of farm families impoverished by repeated droughts. State-wide medical programs were inaugurated in these two states November 1, 1938, for all families receiving help, or who had received help in the past from the Farm Security Administration.

In South Dakota about 40,000 farm families, or half of the farming population, are eligible, and 25,000 families are taking part in the program. In North Dakota, approximately 37,000 families are eligible and about 29,000 of them are participating. These families are members of the North Dakota Farmers' Mutual Aid Corporation or the South Dakota Farmers' Aid Corporation. They pay in advance \$2 per month per family for a minimum period of six months. Families lacking this money receive loans from the

Farm Security Administration to enable them to become members of the Corporation.

The funds are used to pay for emergency medical care, emergency dental care, emergency hospitalization, for prescribed drugs and for home nursing. The North and South Dakota plan renders service only for acute or emergency conditions, and not for chronic illness.

Each farm family that participates in this plan is given an identification card upon which are listed all the dependent members of the family who are entitled to emergency medical care under this plan. The family has the free choice of any physician licensed to practice medicine in the state.

The charges made for medical service are based on a special schedule of fees that have been agreed upon in an understanding worked out by the Inter-Allied Professional Council of South Dakota and the respective State Medical, State Dental, State Hospital and State Pharmaceutical Associations in North Dakota.

In North Dakota the funds are distributed as follows:

For Physicians	51%
For Hospitalization	37%
For Dentists	8%
For drugs and med. supplies	4%

In South Dakota the distribution differs slightly, as follows:

For Physicians	51%
For Hospitalization	30%
For Dentists	15%
For drugs and medical supplies	3%
For nursing care (home)	1%

At the end of each month all physicians, dentists, hospitals

and pharmacists who have rendered services to participants in this plan submit their bills before the 5th of the following month to the State office of the North Dakota Farmers' Mutual Aid Corporation at Bismarck, or the South Dakota Farmers' Aid Corporation at Huron. The bills are then reviewed and totalled. If the total amount of these bills is less than the amount set aside for that period, all bills are paid in full. If the total amount of the bills is in excess of the amount of money set aside for that period, each bill is cut proportionately.

As in any new program, difficulties have arisen at times in the North and South Dakota plan, but both doctors and patients have agreed to co-operate in working out these problems.

In California and Arizona, a different type of medical care program was undertaken, to meet the needs of migratory agricultural workers who required medical attention, but rarely could afford to pay for such aid. The influx of migrants into California and Arizona since 1935 has created a serious public health problem in these two states. Most of them have a low and uncertain income, and live in roadside "jungles" in patched tents or hastily-improvised shelters with no sanitary facilities.

The constant movement of migrants from one farming area to another, sometimes more than 300 miles away, contributed to the rapid spread of communicable diseases. Despite the vigilance of the California State Department of Health, outbreaks of small pox or typhoid in widely separated counties were a potential threat.

In February, 1938 the Farm Security Administration, with the

co-operation of the California Medical Association, the State Department of Health and the State Relief Administration, formed the Agricultural Workers' Health and Medical Association, incorporated under state laws. Each of the agencies has a representative on the Board of Directors of this non-profit association.

Migrants make applications for medical treatment at the association's district offices or camp treatment centers. A certificate of membership in the health association, which serves as an identification card, is issued to the applicant.

He then selects his doctor from a list of participating physicians or is treated by the local part-time physician in charge of the treatment center. The Agricultural Workers' Health and Medical Association is billed for the medical services or hospital services rendered. In many treatment centers, local physicians work in the clinics at designated hours on alternate days. The personnel of the typical treatment centers consists of a part-time doctor, a nurse and a clerk.

Although the migrant-workers are obligated to repay the cost of services "if so requested", their economic status precludes any expectation of repayments in most cases. Some workers, however, have been able to repay a few dollars. In view of the savings effected in the health of the two states under this program, it seems probable that adequate financial support will continue. Similar conditions prevailed in Arizona, and similar measures were undertaken.

There are at present 13 medical care centers in California--at

Marysville, San Jose, Stockton, Chowchilla, Fresno, Bakersfield, Farmersville, Visalia, Shafter, Arvin, Indio, Brewley and Calipatria. In Arizona, there are six--at Phoenix, Buckeye, Tolleson, Chandler, Coolidge and Yuma.

There has not been sufficient experience with any of these various plans to perfect them. Adjustments and changes will be necessary in many of the programs. These programs are not a final answer to all the problems of medical care in rural areas; but it is felt that they are worthwhile examples of methods which may be used in approaching these problems.

- - - - -

4/10/39

Figures as of 4/10/39

